

## TRANSACTIONS OF THE NEW YORK SURGICAL SOCIETY.

*Stated Meeting, January 24, 1894.*

ROBERT ABBE, M.D., President, in the Chair.

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### MULTIPLE EPITHELIOMA.

DR. JOHN A. WYETH presented a man, aged seventy-six, who was the subject of an epithelioma of the nose, of the ear, and of the neck. Three years ago another sore had appeared over the root of the nose which was excised at Bellevue Hospital, November, 1891, and the wound skin-grafted. The one now on his nose and the one on his neck were present at the time, but were very small and were not removed. The one on his ear has been there thirty-five years. He thinks it followed a frost-bite.

Dr. Wyeth said that epithelioma of the ear was rare, and occurred in women about one-tenth as often as in men. Perhaps this was due to the fact that men were more exposed to frost-bite, the most common cause of the disease in this locality. In this patient the site of the epitheliomata on the nose corresponded to places of irritation by glasses.

### LITHOTOMY AND PROSTATECTOMY AFTER FRACTURE OF THE SPINE.

DR. CHARLES K. BRIDGON presented a man, aged fifty years, who four years previously had sustained an injury to his spine in a railway wreck for which he was kept in bed three or four months. During a portion of this time he was completely paralyzed below his waist. He was unable to pass his urine and was catheterized for three months following the injury. His rectum was emptied by means of enemata. In the lower extremities there was also partial anæsthesia, with later paræsthesia. Sensation and motion gradually returned, also control of the bladder and rectum. Before the acci-

dent he was a well-built, robust man, six feet in height. He has never regained his lost flesh and strength, and measurements show him to have lost two inches in height. After three years he began to suffer with symptoms of stone in the bladder. The bladder had been irritable and urination frequent and painful ever since his accident. Examination of the bladder revealed the presence of a stone, which was removed by crushing by a Western surgeon. Most of his symptoms were relieved, but he still urinated frequently and suffered some distress. His vesical symptoms gradually returned, causing him to enter the Presbyterian Hospital for relief in November, 1893. Examination of his spine showed a marked antero-posterior curve, convex posteriorly, with the second lumbar vertebra most prominent; also a slight lateral curve, convex to the left. The spinous processes of the lower cervical vertebræ were unusually prominent. No change in sensation is made out. Patient still complains of abnormal sensations in the lower extremities.

Examination of the bladder revealed the presence of stone.

By suprapubic section five calculi were removed; the largest was the size of a large walnut; some of the smaller ones were apparently fragments left from the former crushing. The middle lobe of the prostate was then found to project into the opening of the urethra for a distance of nearly three-quarters of an inch. By means of loops of silk the bladder-walls were held aside, and the orifice of the prostatic urethra brought into view. The top of the projection of the middle lobe being seized with vulsellum forceps, it was removed with a few cuts of the scissors. The bleeding was controlled with a tampon of gauze, inserted into the urethral orifice after Keyes's method.

An iodoform gauze drain was placed in the bladder, a large aseptic sponge placed over the wound to absorb the escaping urine. A gauze dressing applied and patient sent to the ward.

When presented, the condition of the patient was excellent, his recovery having been uneventful; what remained of the paresis of the lower extremities has been manifestly improved by faradization and massage, the fistulous track communicating with the bladder was closed by the end of the sixth week, and he then had to urinate about every two hours.

The specimen presented was about the size of the ungual phalanx of the thumb. The largest calculus weighed 397 grains, the combined weight of the smaller fragments 125 grains. Composition, ammoniaco-magnesian phosphates.

## PLASTIC OPERATION ON THE HAND.

DR. ARPAD G. GERSTER demonstrated the result of a plastic operation performed on the hand of a woman for deformity following an extensive burn, occupying the dorsum of the thumb, the index, middle, and fore fingers partially, and the fifth finger. The index, middle, and fore fingers were connected by a cicatricial web which extended quite a distance over the middle phalanx. Flexion of the fingers was possible only to a very limited degree, and that in the metacarpo-phalangeal joint. The fingers themselves could hardly be bent. The cicatrix was massive and dense and apparently extended down to the sheath of the extensor tendons. The material for the flap with which to cover the defect after excision of the cicatrix was taken from the inner surface of the other arm. A flap was raised from the arm, containing all the constituents of the skin, and having its base attached on the radial side, both arms were fixed in plaster-of-Paris splint and placed in such relation to each other that the flap was laid easily on the defect on the hand, to which it was loosely attached by three or four stitches to keep it in contact. The two arms were fixed in this relation, suspended, and the patient was put to bed. Ten days afterwards the adhesion of the flap was sufficiently secure to enable him to divide the pedicle. Then the flap, which was a generous one, was divided into a number of finger-like projections which were implanted into the interspaces between the fingers, and were used to cover the dorsum of the corresponding fingers, and the flap was finally attached all round by sutures to the margin of the skin. The ability to flex and use the fingers and hand has improved greatly.

The method employed in this case is known as Maas', and has been used mostly in defects of the lower extremities, especially of the heel. Two cases especially of this character the reporter recalled out of his own experience, in which he had covered extensive defects of the heel, and a third one of extensive defect over the patella. In the latter the whole integument over the patella and the head of the tibia had been torn away in a railroad accident. The flap was taken from the other extremity for its repair, and the result was most satisfactory.

Dr. ABBE remarked that it seemed to him that no method gives better results than the one described, as to sensibility and usefulness of the limb. He doubted whether the Thiersch graft would give as much flexibility and solidity as had been obtained in this case by Dr. Gerster. Still, in his experience Thiersch's grafting gave much

satisfaction, especially in cases of defect around the wrist. In two or three cases under his care these grafts had thickened up in the course of time. Although they ever remained mosaics, yet they become thickened like true skin and do not break down. In one of the cases both wrists were encircled by ulcers, following the burning of a pair of celluloid cuffs *in situ*. The burning was to the third degree. Thiersch's grafts were applied and gave a perfectly satisfactory result. He had used the method described by Dr. Gerster with admirable results in a case of defect at the heel; also in a case of defect on the palm of the hand, although in the latter instance the mass was rather voluminous and flabby. It was taken from the thigh.

#### TORSION FOR THE CURE OF RECTAL INCONTINENCE.

DR. ARPAD G. GERSTER read a paper in which he stated that in the causation of rectal incontinence two factors are to be considered, —first, the inefficiency or absence of the sphincter muscle; and, secondly, the character of the digestive process, upon which depends the state of cohesion or solidity or fluidity of the *fæces* when they approach the breach.

The latter factor in most instances can be influenced so as to enable the patient to hold his stool for twenty-four hours. Properly-selected diet, astringents, and small doses of opium will produce a solid column of *fæces*. But in a small fraction of cases, where the peristaltic motion is habitually lively, all these expedients will fail, and the patient's condition is then pitiable indeed.

In considering the remaining factor,—that is, the state of the occlusive apparatus of the breach, while incontinence due to paralysis of the sphincter caused by spinal disease or injury should be mentioned, for obvious reasons he did not intend to dwell on it at this time.

In a more numerous class of cases the sphincter has been rendered useless by one or more incisions, carried through its entire thickness by the surgeon's knife, usually for the cure of fistula. Whenever these incisions are not too numerous, the nerve-supply of the divided segments of the muscle intact, they should be reunited by suture, and the result will be very satisfactory. Where the nerve-supply is permanently damaged by incisions, cicatricial retraction and atrophy having followed, this plan will be found non-feasible. Plastic measures directed towards the mere narrowing of the breach are also

of a very doubtful value, and torsion will be found a most valuable aid in re-establishing continence.

The function of the sphincter is sometimes damaged by ulcerative processes in its neighborhood, followed by massive cicatricial deposit in and around this muscle, resulting in stricture. In these cases rebellious constipation alternates with just as obstinate diarrhoea. During the latter incontinence is the most distressing feature of the trouble.

As in the preceding group, so was surgery hitherto unable in this latter one to afford permanent relief. At present, after excision of the cicatrix, torsion offers a very fair promise of success.

Next must be considered the cases in which the sphincter is entirely absent. This absence may be congenital or acquired.

Congenital absence of the sphincter occurs often in congenital atresia of the anus and oftener in atresia of the rectum. Dr. Gerster observed one of these cases in an adolescent complicated by prolapse, and cured the trouble by torsion.

Torsion was first employed in surgery by Gersuny, of Vienna, who published in *Centralblatt für Chirurgie*, 1889, a successful cure by torsion of a case of vesical incontinence due to paralysis of the sphincter. In the beginning of 1893 he transferred the same principle to two cases in which the rectum and sphincter had been excised for neoplasm. The procedure is very simple, and consists in the rotation around its own axis of the freed end of the gut, so as to arrange the rectal walls into a rather close spiral twist. The twisted gut is then stitched to the edges of the outer wound. To make a comparison, a smooth bore, as it were, is thus converted into a rifle. The amount of torsion is to be gauged by the amount of resistance felt by the index finger on introduction.

The greatest number of cases of incontinence is produced by operations, wherein the sphincter must be sacrificed in eradicating neoplasms. Here torsion is eminently indicated as the concluding step of the operation. It does not involve additional risk by loss of time or loss of blood, and its results are excellent, as Gersuny's and Gerster's cases show. The author recounted the history of a case of incontinence, following extirpation of the rectum, in which the trouble was cured by torsion. This patient was presented to the Surgical Society. Torsion would seem to be applicable also to certain cases of colotomy.

The amount of torsion which Dr. Gerster had made had been

graduated according to the amount of resistance encountered. While he did not make more than one complete twist in the two cases reported, he would not hesitate to do so if it were necessary. If the loosened end of the rectum were long it might be necessary to make more than one circle of torsion. For example, if five or six inches of the rectum had been excised, and the loosened end drawn down, it is probable that more than 360 degrees torsion would be necessary in order to secure the amount of resistance that is desirable. If the rectum was not twisted at once, the surgeon would have to wait for the rectum to become fixed by a deposit of granulations to the adjoining soft parts, then loosen the lower end two or three inches, and twist it to the degree which might be required. Experience will have to teach which of these procedures will deserve the preference. He had never employed torsion immediately after extirpation. In both of these cases reported the rectum was dissected out, the proximal end where the dissection ceased was firmly attached, and formed a fixed point, from which torsion was made.

#### CASE OF INTRAUTERINE AMPUTATION.

DR. A. J. McCOSH presented a patient illustrating intrauterine amputation of the arms. He said: "The baby is eleven weeks old, the child of healthy young parents. There was nothing peculiar about the pregnancy from beginning to end. There is no history of traumatism or of syphilis. The mother was delivered by a midwife; the labor was not especially severe or protracted. The baby was born with the right upper extremity terminating apparently at the elbow, the left at a point which would be about the junction of the lower and middle third of the arm. The forearm on each side is wanting. On the end of the left arm are two minute fleshy projections. The left thigh shows a deformity due to bending of the femur near its middle, and subsequent ossification in this faulty position. Both the midwife and the mother are positive that none of the amputated members were expelled either with the child, or placenta, or in the lochia." Since there is nothing in the history to account for the amputations, the reporter fell back upon the theory of amniotic folds, or of strangulation by the cord.

DR. ABBE remarked, regarding Dr. McCosh's case, that the spreading out of the end of the humerus, and the presence of two or three fleshy growths, would seem to point to arrested develop-

ment with an attempt at the formation of the elbow and rudimentary fingers rather than to amputation.

Dr. McCOSH was still inclined to think the case was one of amputation, although it was impossible to say so with certainty. There was a difference of an inch and a quarter in the length of the two stumps, and the deformity of the thigh appeared to him to be due to a like cause,—*i.e.*, pressure by an amniotic fold, which, however, was removed before complete severance of the limb had occurred.

Dr. BRIDGON said he had presented a specimen before the Pathological Society about twenty-five years ago somewhat similar to Dr. McCosh's case. It called out a good deal of discussion as to the cause of the condition, whether it was due to arrested development or to amputation by the funis. In his case it was thought not to be due to arrest of development, nor to amputation by the funis, but rather to amputation by some other constricting band. One thigh was cut down to the bone as if by a thread, yet the leg on that side was of the same size as the other. He believed the fingers and thumb of the opposite upper extremity were similarly involved, so that it seemed impossible for the funis to have been the cause, especially as this was found at the labor around the child's neck, and in a healthy condition.

#### CASE OF HYPERTROPHY OF THE TIBIA.

Dr. McCOSH presented a girl, ten years of age, who had always been, except for the condition shown, a healthy child, having had none of the exanthemata, and giving no history of continued fever during childhood. About two years and a half ago the mother noticed that the left leg was longer than its fellow, and that there was a distinct bend in the middle of the tibia. The curvature has been slowly but steadily increasing, as has also the length of the leg, until now it is two inches and a half longer than the right. The increase in length has been entirely in the diaphysis of the bone, below the tuberosity of the tibia. There has also been an increase in the thickness of the tibia. The bone feels perfectly smooth and the enlargement is uniform. There has never been any pain or tenderness on pressure. The girl walks almost without a limp, the pelvis being tilted. There is no history of injury. The question arises, What is the cause of the increased length of the tibia? Has it been caused by an osteo-myelitis which has left a sequestrum either in the head or in the shaft of the bone, by a

syphilitic osteitis, or by a new growth? There is a specific history on the father's side, and the mother has also probably had syphilis. He requested the opinion of the members with regard to the causation and the treatment.

Dr. GERSTER was inclined to look upon Dr. McCosh's second case as one of congenital syphilis, rather than one of a simple inflammatory condition, allied with the various forms of osteo-myelitis. He had observed cases identical with this, having marked elongation of the tibia with curvature forward, and in several had performed an operation to correct the deformity. The characteristic sclerotic osteitis peculiar to congenital syphilis—the bone resembling ivory—was found. The bone was very anæmic, the solid constituents very dense and massive, the medullary canal obliterated. The protuberance was chiselled away, but the elongation was not so great that he had thought it necessary to shorten the bone. In children there was pain, thickening of the periosteum, the outer surface of the bone being more vascular than the deeper portion, pointing apparently to a still active process. He had been gratified to see that the process had ceased after the operation. It would seem, therefore, that removal of the upper layer of bone stops the process, and causes the pain and other inconveniences suffered by the patient to disappear, to a considerable extent at least. If the elongation were to become much more marked in the case presented, he thought shortening the limb by excision could be considered.

#### CESSATION OF EPILEPSY AFTER TREPHINING AND TYPHOID FEVER.

Dr. McCosh presented a third case, that of a girl, seven years of age, who had been an epileptic a number of years, having had as many as five or six convulsions a day. There was partial paralysis of the right upper extremity with some atrophy of the muscles. The same condition existed in the right lower extremity, but in less degree. He trephined her in March, 1893, over the left motor area, and after removing a considerable area of bone, came down upon a reddish membrane situated between the dura and brain, which was as thick as a sheet of note-paper and about two inches in diameter. It was removed. The convulsions appeared atrophic. She made a rapid recovery from the operation. The convulsions, however, were but little altered, but there was slight improvement in the paralysis.

The peculiar point in the case, however, is to come. At the end



of the following September the convulsions became more numerous, twelve to eighteen in twenty-four hours, and she was sent to hospital for further operative treatment.

After she had been there a day or so, she was found to have typhoid fever. The case ran the usual course, although it was somewhat prolonged and severe; but since the first week of the fever the child has not had a convulsion or spasm of any kind. It is now two months since the fever has ceased, and not a convulsion or even a twitching has occurred. She is brighter and appears better in every way, even the paralysis of the muscles having improved.

Dr. WYETH said that he had seen an analogous condition in two patients,—namely, adhesion between the dura, pia, and the brain in epileptics, in one there being also atrophy of the underlying convolutions. In one marked improvement followed trephining during about six months, then the attacks recurred, but were less severe and less frequent than previously. Dr. Wyeth then related the histories of two cases in which he had recently trephined for epilepsy. Immediate improvement had followed in each instance, but the ultimate result was yet to be seen.

Dr. ABBE remarked that it seemed to him that surgery is lacking in some measure with regard to remedying the defect of adherent dura and brain. This lack had the promise of being filled by Dr. Beach, of Boston, who had trephined in a case of epilepsy, freed the adhesions between the dura and brain, and there was relief from the convulsions about the usual time,—six months. They then recurred. He exposed the area a second time, freed the adhesions, and put in a sterilized plate of gold foil upon the brain to prevent the reformation of the adhesions. About two months afterwards the convulsions had not recurred. This seems an ingenious and perhaps useful method of preventing the immediate formation of adhesions between brain and membranes after trephining, for it would seem that simply breaking up the adhesions could be of only temporary benefit.

Dr. GERSTER said that he had demonstrated last winter before the Neurological Society a patient on whom Beach's plan had been applied. It was a case of cyst of the motor area, with characteristic Jacksonian epilepsy. The cyst was exposed and drained, and after three or four months the epileptic seizures, which had never resulted in total unconsciousness, returned, and as adhesions had evidently formed at the site of the operation, he adopted Beach's plan and implanted a piece of gold foil between the brain and dura, ascer-

taining at the same time that the cyst had not reformed. The girl was free from seizures again for three months, but they then recurred. He believed that the epileptic seizures did not depend upon adhesions at all, and that if they were not due to the establishment of a vicious circle, the cause was cicatricial deposit in the brain-matter. We cannot make a puncture or resection or do anything to the gray matter without causing a cicatrix, and, therefore, he was not as much of an enthusiast as some are with regard to the success to be obtained by operation in cases of epilepsy. Yet if we cause only a temporary cessation of numerous and severe convulsions, such as were present in Dr. McCosh's case, we are accomplishing a great deal.

#### STRANGULATED HERNIA OF A FALLOPIAN TUBE.

DR. JOHN A. WYETH narrated the history of a woman, aged thirty-eight years, upon whom he had been called to operate when *in extremis* from what appeared to be a strangulated right inguinal hernia. In the sac when opened was found simply a swollen, darkly-congested Fallopian tube. Pus and fæces welled up from the abdominal cavity through the neck of the sac. Free enlargement of the incision through the abdominal wall revealed a loop of small intestine gangrenous and ruptured, having been caught and strangulated by an old adhesive band. An artificial anus was made after the abdominal cavity had been cleansed. The patient died six hours later.